**Thank you for contacting Tobii Dynavox and starting the Funding process for your replacement battery/charger.**

The attached documentation needs to be completed and returned to Tobii Dynavox. This documentation is necessary for Tobii Dynavox to obtain in advance so we can attempt to obtain authorization and bill your insurance company(s) for the equipment. The attached documentation includes: Client Information Form; Release of Benefits; Repair Physician's Prescription Form; Letter of Medical Necessity (Sample to provide to your SLP or Physician).

**Please follow the steps below:**

- Please ensure that the Client Information Form and Release of Benefits are completed and signed.
- The prescription form must be completed and signed by a licensed physician.
- The Letter of Medical Necessity may be completed by a speech language pathologist or physician. In most cases the letter of medical necessity can be provided by the same physician completing the prescription, if you do not currently have a speech language pathologist. The Letter of Medical Necessity must be dated and signed. The attached version is a sample only.
- Missing information will most likely delay the repair process as documentation may need to clarified or additional information may need to be obtained.
- Tobii Dynavox cannot submit to insurance(s) for authorization of services unless we have the required documentation.
- If your place of residence (Home, Skilled Nursing Facility, etc) has changed since your previous order the insurances may or may not cover the new place of service. Tobii Dynavox will not be able to determine coverage for the repair until we have verified the current place of service.

Please email, fax, or mail all completed paperwork to one of the below locations, along with photo copies of all medical insurance cards, at your earliest convenience.

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1) For sending to Tobii Dynavox via Standard U.S. Mail:

Attention: Funding Department
Tobii Dynavox
2100 Wharton Street, Suite 400
Pittsburgh, PA 15203

2) For sending to Tobii Dynavox via Facsimile (FAX)

Fax Number:
866-336-2737

3) For sending to Tobii Dynavox via email, with scanned and attached documents:

Electronic Document Email:
funding@tobiidynavox.com

Sincerely,

The Tobii Dynavox Funding Department

# Tobii Dynavox Client Information Form

(must be completed and returned)

Today's Date: _____ Device Serial #: _____

## Section 1: Client

First Name: _____ Middle Name: _____ Last Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Phone Number: _____ Alt. Number: _____

Current Place of Residence: ☐ Home or ☐ Facility Facility Name (if applicable): _____ Facility NPI (if applicable): _____

Gender: ☐ M ☐ F Email: _____

## Section 2: Family Contact/Legal Guardian

First Name: _____ Last Name: _____ Relation to client: _____

Phone Number: _____ Alt Number: _____ Email: _____

## Section 3: Speech Language Pathologist/Evaluator

First Name: _____ Last Name: _____ Phone Number: _____

Fax Number: _____ Alt Number: _____ Email: _____

Alternate Contact Person: _____

## Section 4: Treating Physician

First Name: _____ Last Name: _____ State License Number: _____

Phone Number: _____ Fax Number: _____ National Provider Identifier (NPI): _____

## Section 5: Insurance Coverage(s)

Medicare Number: _____ Medicaid Number: _____

**Please include ALL insurances and alternative funding sources**

1. Name of Insurance: _____ Policy Number: _____ Phone Number: _____

Policy Holder First Name: _____ Policy Holder Last Name: _____ Policy Holder DOB: _____

2. Name of Insurance: _____ Policy Number: _____ Phone Number: _____

Policy Holder First Name: _____ Policy Holder Last Name: _____ Policy Holder DOB: _____

## Section 6: Shipping Information

**Please provide a location where the equipment can be signed for when delivered. PO BOXES cannot be accepted.**

Contact Name: _____ Facility Name: _____ Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

*I verify that all information contained herein is correct and true to the best of my knowledge. I also understand that the information provided will be used by Tobii Dynavox for the purpose of obtaining funding and hereby give permission to Tobii Dynavox to release this information as required by the funding sources listed.*

Signature _____ Date _____

Please send completed Funding information to: Tobii Dynavox, 2100 Wharton St. Ste 400, Pittsburgh, PA 15203 or via fax to 866-336-2737 Attn: Funded Repairs or via email to funding@tobiidynavox.com

# Lifetime Release & Assignment of Benefits Payment Agreement

(must be completed & returned)

I authorize the release of any medical or other information necessary for determining benefits payable for equipment or services and processing claims by the Centers for Medicare & Medicaid Services, my insurance carrier and any other medical/insurance entity. I understand that on occasion, funding or reimbursement barriers are encountered. Tobii Dynavox works in conjunction with Disability law Centers on behalf of customers to overcome these barriers to ensure that funding is obtained. I hereby authorize, if necessary, Tobii Dynavox to release information related to my claim for funding to these Disability Law Centers.

I authorize payment of insurance benefits, including Medicare if applicable, be made either to me or on my behalf to Tobii Dynavox for any equipment or services provided to me. Should I receive payment directly from the insurance company, I agree to forward the check and "Explanation of Benets" to Tobii Dynavox with in 10 days of receipt. I understand that the check and explanation are due to Tobii Dynavox in order to credit my account. If I fail to provide this information, I understand that I will be held legally responsible for payment in full for all equipment or services which have been provided by Tobii Dynavox.

I understand that I am financially responsible to Tobii Dynavox for any charges not covered by health care benefits. I agree to notify Tobii Dynavox of any changes in my health care insurance coverage. In some cases, exact insurance benefits cannot be determined until the insurance company receives the claim. I understand that I am responsible for the entire bill or balance of the bill as determined by Tobii Dynavox and/or my health care insurer if the submitted claims, or any part of them, are denied for payment.

I understand that by signing this form, I am accepting financial responsibility as explained above for all payment for products received. THIS DOES NOT APPLY WHEN MEDICARE DETERMINES THE BALANCE TO BE THE CONTRACTOR'S OBLIGATION, OR TO MEDICAID RECIPIENTS.

I have read and understand the Tobii Dynavox 30 Day Return Policy, Patient Bill of Rights and Responsibilities (which includes the process to file a grievance or complaint with the Company), the Tobii Dynavox Supplier Standards, per DMEPOS, and the Tobii Dynavox Notice of Privacy Practices.

☐ Please check if client is currently receiving hospice care ☐ Please check if client is currently in a skilled nursing facility

Client Name (User): _____

Policy Holder Name if different from Client: _____

Policy Holder SSN if different from Client: _____ - _____ - _____

Policy Holder Date of Birth if different from Client: _____ / _____ /_____

*****Form must be signed and dated below to be valid*****

Client/Insured/Legal Guardian/Power of Attorney
(mark acceptable with Witness Signature): _____ Relationship to Client: _____ Date: _____

Witness Signature (valid with client mark only): _____ Relationship to Client: _____ Date: _____





2100 Wharton Street • Suite 400 • Pittsburgh, PA 15203
Customer Support: 1-800-344-1778 • CSS@tobiidynavox.com

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## PHYSICIAN PRESCRIPTION

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***Patient Information*** ***Order Date:*** _____

Patient Name: _____ Date of birth: _____

Insurance ID: _____ Address: _____

***Clinical information***

Medical Diagnosis: _____

Communication Diagnosis: _____

Length of Need: Lifetime ☐ Other: _____

Prognosis: Good with use of Speech Generating Device ☐ Other: _____

Date of last Face-to-face visit (must be within last 6 months): _____

***Equipment Prescribed***

| Equipment Description | Quantity |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

***Mount needed: (circle one) Yes NO***

***Physician Information:***

I have reviewed a copy of the Speech Language Pathologist's completed communication evaluation for the above patient and agree with the recommendation for the listed equipment. The prescribed device and accessories are necessary to achieve the functional communication goals for this patient as noted in the SLP's treatment plan.

Physician's Printed Name: _____ NPI: _____

Medicaid ID: _____ Phone: _____

Address: _____

***Physician Signature:*** _____ ***Date:*** _____

*Signature/Date stamps are not permitted*

**Return via fax to: 1-866-336-2737 or via email to: funding@tobiidynavox.com**

# SAMPLE LETTER

Client's name:
Date of Birth:

To Whom It May Concern:

I am currently (patient's) speech therapist. (Patient) suffers from (medical diagnosis) resulting in (communication diagnosis). (Patient's) inability to speak necessitates an augmentative communication device in order to express (his/her) medical and personal needs and communicate with family, medical personnel and caregivers.

(Patient) has successfully used a speech generating device since (date of purchase and serial #) and it continues to be the most appropriate device. (His/her) speech ability remains chronic and improvement is not likely. At this time, (Patient's) speech generating device is in need a replacement (battery, charger, or battery and charger). I recommend purchase of this equipment as (Patient) continues to benefit from the use of this device.

Sincerely,

Speech Therapist
Address
Phone
DATE